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	495168	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/30/18 through 02/01/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/30/18 through 02/01/18. An extended survey was conducted on 02/01/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Substandard Quality of Care was identified in the area of Quality of Care with a Scope and Severity of Level II, widespread. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 93 certified bed facility was 79 at the time of the survey. The survey sample consisted of eighteen current resident reviews and four closed record reviews.	F 000	Shenandoah Valley Health and Rehab Facility is filing this Plan of Correction for purposes of regulatory compliance. The Facility is submitting this Plan of Correction to comply with applicable law. The submission of the plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550	1. Resident #83 remains in facility. Resident was provided a cover for her suprapubic bag during survey.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelsie J Coleman | TITLE: Administrator | (X6) DATE: 2/23/18

...iency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to promote the dignity of one of 22 residents in the survey sample. Resident #83 had a urinary catheter collection bag without a privacy cover resulting in collected urine visible to residents, staff and visitors.	F 550	2. Residents that have a foley or suprapubic catheter requiring bags will have covers placed. These resident have the potential to be affected by this deficient practice. 3. Audits will be completed during care keeper rounds on residents with a foley or suprapubic catheters to ensure covers are in place 5x per week for three months. Nursing staff will be re-educated on dignity and the use of covers for catheter bags 4. Results of audits will be taken to the quarterly Quality Assurance Performance Improvement for review and any discrepancies will be corrected immediately. 5. Corrective action will be completed on March 1, 2018.	

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F 550	Continued From page 2	F 550		

The findings include

Resident #83 was admitted to the facility on 12/26/17 with diagnoses that included sacral pressure ulcer, high blood pressure, anemia and osteomyelitis. The minimum data set (MDS) dated 1/9/18 assessed Resident #83 as cognitively intact.

On 1/30/18 at 10:55 a.m., Resident #83 was observed in bed. Attached to the lower rail on her bed was a urinary catheter collection bag over half full of urine. The bag had no privacy cover with urine visible in the bag upon entrance to the room. The resident had a family visitor in the room at the time of the observation. The catheter collection bag was observed again on 1/30/18 at 12:34 p.m. attached to the bed rail without a privacy cover.

On 1/30/18 at 1:37 p.m., Resident #83 was interviewed about a privacy cover for her urine collection bag. The resident stated she did not have a cover for the bag and the bag had not been covered since she had been in the facility. The resident stated she preferred to have it covered so her urine was not visible.

On 1/30/18 at 3:10 p.m., the licensed practical nurse (LPN #3) caring for Resident #83 was interviewed about a privacy cover for the resident's urine bag. LPN #3 stated the resident was admitted with a different shaped collection bag than what was stocked at the facility. LPN #3 stated the urine bag was positioned on the bed and was visible to the resident and others.

On 1/31/18 at 9:06 a.m., Resident #83 observed in bed with a fabric cover over her urine collection

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F 550	Continued From page 3 bag. Resident #83 was interviewed at this time about the cover. Resident #83 stated she was pleased with the cover as it prevented everyone from seeing her urine in the bag. These findings were reviewed with the administrator and director of nursing during a meeting on 1/31/18 at 3:50 p.m.	F 550		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	1. Residents #52, #58, and #59 remain in the facility. Care plans have been updated to reflect current plan of care. 2. Residents in the facility have the potential for an inaccurate/incomplete care plan. 3. Education will be provided by the VP of Clinical Reimbursement / designee to the Interdisciplinary Care Plan Team to ensure care plans are created and updated as needed to reflect resident's overall condition. Nursing staff will be re-educated by the DON/Designee on updating care plans to reflect any changes in patient care. Care plans will be audited weekly following the routine care plan schedule over	

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F 656	Continued From page 4 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop and implement a CCP (Comprehensive Care Plan) for three of 22 residents in the survey sample, Resident # 52, # 59 and # 58. 1. The facility staff failed to develop a CCP for Resident # 52 in the area of hearing. 2. Resident #59 did not have a comprehensive care plan developed to address her vegetarian diet choice or the use of an anticoagulant. 3. Resident #58 had no plan of care developed regarding use of an elastic support dressing applied to the resident's arm for treatment of edema. Findings include: 1. The facility staff failed to develop a CCP for Resident # 52 in the area of hearing.	F 656	the next three months to ensure they are current and accurate. 4. Results of audits will be taken to the monthly / quarterly Quality Assurance Performance Improvement for review and re-education given as needed. 5. Corrective action will be completed on March 1, 2018.	

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Resident # 52 was admitted to the facility on 10/01/14 with diagnoses including, but not limited to: major depressive disorder, anxiety disorder, high blood pressure, hypothyroidism, and urinary retention. The resident did not have an actual diagnoses of hearing loss listed on the resident's CCP or POS (physician's order set).

The most current MDS (minimum data set) was a quarterly assessment dated 12/20/17. This MDS assessed the resident as having a cognitive score of "3", indicating the resident was severely impaired in daily decision making skills. The resident was also assessed on this MDS, as having moderate difficulty hearing and not having/using a hearing aid or device.

On 01/30/18 at 10:45 a.m. during the initial tour of the facility, Resident # 52 was observed in her room laying in bed. This surveyor knocked on the door and requested to come in. The resident did not respond. The same was done, with a louder knock and tone of voice and the resident did not respond. The resident was looking at the door area, but did not respond. The surveyor moved closer and spoke in a very loud tone and the resident said, "What" and then attempted to sit up on the side of the bed. The surveyor made introductions in a very loud tone, but the resident could not hear what was being said.

02/01/18 08:04 AM the resident was observed in the day room area close to the nursing station and near the resident's room. The resident is in a w/c, the resident was spoken to again, but the resident is very HOH (hard of hearing).

The resident's clinical record was reviewed and no evidence was found that the resident had any

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F 656	Continued From page 6	F 656		

type of hearing aids or devices. No evidence could be found that the resident had seen an audiologist or had any type of consult for the hearing loss. No information was found in the resident's clinical record to indicate what caused the hearing loss or how long the resident had the hearing loss.

The resident's CCP documented, "...at risk for falls...cognition impairment, blind in L (left) eye, hearing impairment....impaired neurological status...HOH [hard of hearing]...Hearing and/or vision consultation as needed..." This CCP was initiated on 10/01/14, the resident's original admission and has a revision date of 01/16/17, but no actual revision was seen-only a revision date.

On 02/01/18 at 10:55 AM The ADON was interviewed regarding Resident # 52's hearing loss and difficulty communicating due to the hearing loss. The ADON stated that the resident did not have a hearing aid and could not remember the resident having one in the past, but did think that the resident had been tried on an amplifier at one point, but could not remember and would have to look that up. The ADON was informed of the resident's CCP (comprehensive care plan) having minimal information and interventions regarding the resident's extensive hearing loss and no information regarding any type of assistive hearing devices. The ADON was asked if the resident had any type of consultation for hearing, as referenced in the resident's CCP. The ADON stated that she would look for that information.

On 02/01/18 at 11:50 AM, the ADON stated that there was no hearing consultation of any kind

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found for Resident # 52 and further stated that medical records is looking.

The administrator and DON (director of nursing) was informed on 02/10/18 at approximately 2:30 p.m., in a meeting with the survey team.

No further information and/or documentation was presented prior to the exit conference on 02/01/18 at 4:00 p.m.

2. Resident #59 did not have a comprehensive care plan developed to address her vegetarian diet choice or the use of an anticoagulant.

Resident #59 was admitted to the facility on 12/15/2017 with the following diagnoses, but not limited to: Major depressive disorder, urinary tract infection, degenerative disease of the nervous system,and hypothyroidism.

The admission MDS (minimum data set) assessed Resident #59 as having a cognitive summary score of "15", indicating she was cognitively intact.

Resident #59 was interviewed on 01/30/2018 regarding her life at the facility. During the interview, Resident #59 stated that she was a vegetarian by choice.

The clinical record was reviewed on 01/30/2018 at approximately 3:00 p.m. Observed on the physician order section was an order for "Lovenox [an anticoagulant] 40 mg/0.4 ml Inject 0.4 ml subcutaneously one tine a day for DVT [deep vein thrombosis] prophylaxis."

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The care plan was reviewed. There were no interventions for Resident #59's vegetarian status or information regarding her anticoagulation therapy.

The above information was discussed during a meeting on 01/31/2018. The DON [director of nursing] stated, "We'll get that."

On 02/01/2018 the ADON (assistant director of nursing) presented updated care plans for Resident #59. The ADON was asked who updated and developed the care plans. She stated, "Nursing and MDS are responsible for the care plans."

No further information was obtained prior to the exit conference on 02/01/2018.

3. Resident #58 had no plan of care developed regarding use of an elastic support dressing applied to the resident's right arm for treatment of edema.

Resident #58 was admitted to the facility on 6/2/17 with a re-admission on 9/21/17. Diagnoses for Resident #58 included high blood pressure, diabetes, heart disease, depression, anxiety, history of breast cancer, lymphedema and chronic kidney disease. The minimum data set (MDS) dated 12/27/17 assessed Resident #53 with moderately impaired cognitive skills.

On 1/31/18 at 8:35 a.m., Resident #58 was observed in her wheelchair with an elastic wrap/bandage covering her right arm. Resident

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#58 stated at this time the elastic support dressing was for treatment of swelling following surgery for breast cancer. Resident #58 stated therapy applied the elastic wrap several times each week and was working toward ordering her a support "sleeve" to help with the swelling in her arm.

Resident #58's clinical record documented a physician's order dated 11/8/17 for occupational therapy to evaluate and treat the resident regarding lymphedema in the right arm. A physician's order dated 1/9/18 documented occupational therapy three times per week that included application of the wrap for treatment of lymphedema.

The resident's plan of care (print date 1/31/18) had no problems, goals and/or interventions regarding use of the elastic wrap on her right arm. The care plan listed the resident had a history of lymphedema but made no mention or reference to use of the elastic dressing/wrap.

On 1/31/18 at 8:52 a.m., the registered nurse (RN #3) caring for Resident #58 was interviewed about the elastic support dressing. RN #3 stated the support wrap was for treatment of lymphedema in the resident's right arm. RN #3 stated therapy applied the support dressing. RN #3 stated she did not know why the elastic wrap was not on the care plan.

On 1/31/18 at 9:00 a.m., the licensed practical nurse (LPN #1) responsible for MDS and care plans was interviewed about Resident #58's arm wrap. LPN #1 looked through the care plan and stated she did not see anything on the care plan about the support dressing. LPN #1 stated

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F 656	Continued From page 10 therapy applied the wrap to the resident's arm. On 1/31/18 at 3:00 p.m. the occupational therapist (OT) that cared for Resident #58 was interviewed. The OT stated Resident #58 was seen three times per week for treatment of lymphedema in the right arm. The OT stated the support wrap had been successful in reducing swelling in the resident's arm. The OT stated she had a treatment plan in therapy concerning the wrap. The OT stated she communicated weekly to the nursing staff about the resident's progress and participated in daily meetings with the MDS coordinator. The OT stated she did not know why the support dressing was not part of the interdisciplinary plan of care for Resident #58. These findings were reviewed with the administrator and director of nursing during a meeting on 1/31/18 at 3:50 p.m.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657	1. Residents #8, #25, #51, #59, and #60 remain in the facility. Care plans have been updated to reflect current plan of care. 2. Residents in the facility have the potential for an inaccurate/incomplete care plan.	

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F 657	Continued From page 11 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on, staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan for five of 22 residents, Residents #25, #59, #60, #8, and #51. 1. Resident (R 25) care plan was not revised to include interventions regarding mood and behaviors. 2. The facility staff failed to remove foley catheter care from Resident #59's care plan after the catheter was discontinued. 3. Facility staff failed to remove Coumadin therapy and lab work (PT/INR) from Resident #60's care plan after the medication was discontinued. 4. Facility staff failed to update Resident #8's CCP (comprehensive care plan) to include this resident's overall decline in her health status. 5. Resident 51's care plan was not revised to include care and treatment for a new pressure sore.	F 657	3. Education will be provided by the VP of Clinical Reimbursement / designee to the Interdisciplinary Care Plan Team to ensure care plans are created and updated as needed to reflect resident's overall condition. Nursing staff will be re-educated by the DON/Designee on updating care plans to reflect any changes in patient care. Care plans will be audited weekly following the routine care plan schedule over the next three months to ensure they are current and accurate. 4. Results of audits will be taken to the monthly / quarterly Quality Assurance Performance Improvement for review and re-education given as needed. 5. Corrective action will be completed on March 1, 2018.	

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SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE, PO BOX 711 BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Findings include:

1. Resident (R 25) care plan was not revised to include interventions regarding mood and behaviors.

1. R 25 was admitted to the facility on 1/25/12 with diagnoses that included depression.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/22/17. R 25 was assessed as being moderately cognitively impaired.

R 25's electronic record was reviewed on 1/31/18. R 25's care plan review documented a care plan for mood and behavior with a history of refusals, combativeness, yelling out related to depression disorder and psychotropic and antidepressant medications. According to care plan documentation this care plan was last revised on 1/22/18.

Review of the interventions for mood and behavior care plan did not include diversional or redirection prompts and only generalizing 1:1 activities (not specific). Other interventions for this care plan only included, give, monitor, and review medications.

On 02/01/18 08:14 AM License practical nurse, MDS coordinator (LPN #1) was interviewed concerning the care plan regarding altered mood and behavior interventions. LPN #1 reviewed interventions and agreed that the care plan needed to be addressed and updated to include non pharmacological interventions.

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On 2/1/18 at 2:00 p.m. the above finding was brought to the attention of the director of nursing and administrator during a meeting. The DON or administrator did not comment.

No further information was presented prior to exit conference on 2/1/18.

2. The facility staff failed to remove Foley catheter care from Resident #59's care plan after the catheter was discontinued.

Resident #59 was admitted to the facility on 12/15/2017 with the following diagnoses, but not limited to: Major depressive disorder, urinary tract infection, degenerative disease of the nervous system,and hypothyroidism.

The admission MDS (minimum data set) assessed Resident #59 as having a cognitive summary score of "15", indicating she was cognitively intact.

Resident #59 was interviewed on 01/30/2018 regarding her life at the facility. During the interview, Resident#59 stated that when she came to the facility she had a catheter but the facility had helped her with bladder training and now she had it out.

The clinical record was reviewed on 01/30/2018 at approximately 3:00 p.m. The care plan was reviewed. There were interventions for Resident #59's Foley catheter care including but not limited to: size of catheter, timing of catheter bag changes, and catheter care every shift.

The above information was discussed during a

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meeting on 01/31/2018. The administrative team was asked when the catheter should have come off of the care pan. The DON [director of nursing] stated, "When it was discontinued."

On 02/01/2018 the ADON (assistant director of nursing) presented updated care plans for Resident #59. The ADON was asked who updated and developed the care plans. She stated, "Nursing and MDS are responsible for the care plans."

No further information was obtained prior to the exit conference on 02/01/2018.

3. Facility staff failed to remove Coumadin therapy and lab work (PT/INR) from Resident #60's care plan after the medication was discontinued.
Resident #60 was originally admitted to the facility on 04/19/16 and readmitted on 12/22/17 with diagnoses including, but not limited to: ESRD (end stage renal disease) requiring HD (hemodialysis), Respiratory Failure, Pleural Effusion, Pneumonia, Urinary Retention, Diabetes, Hypertension, Anxiety and Depression.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 12/29/17. Resident #60 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #60's clinical record was reviewed on 01/30/18 at approximately 3:00 p.m. During review of the CCP an intervention for Coumadin therapy and PT/INR labs was noted. This focus

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area and intervention was added to the CCP on 10/10/17 for a DVT (deep vein thrombosis).

Subsequent review of the physician orders and MAR (medication administration sheet) for the survey dates of 01/30/18 through 02/01/18 showed this medication and labs had been discontinued. The CCP had not been updated to reflect these changes in Resident #60's plan of care (POC).

The ADON (assistant director of nursing) was interviewed on 02/01/18 at approximately 11:54 a.m. regarding who is responsible for updating the CCP. The ADON stated, "Mostly nursing, but all departments can update for themselves."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 02/01/18 at approximately 2:05 p.m. No further information was received by the survey team prior to the exit conference on 02/01/18.

4. Facility failed to update Resident #8's CCP (comprehensive care plan) to include this resident's overall decline in her health status.

Resident #8 was originally admitted to the facility on 09/22/14 and readmitted on 04/29/16 with diagnoses including, but not limited to: Dementia with behaviors, Abnormal posture, Spinal Stenosis, CVA (cerebrovascular accident), Parkinson's Disease and Hemiplegia.

The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 11/01/17. Resident #8 was

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assessed as severely impaired in her short and long term memory and daily decision making skills.

Throughout the survey 01/30/18 through 02/01/18 Resident #8 was observed lying in bed, positioned side to side with pillows and a concave mattress. Resident #8 had her eyes closed, quarter siderails in place and folded washcloths in each palm.

The clinical record of Resident #8 was reviewed on 01/31/18 at 8:30 a.m. Review of Resident #8's CCP (comprehensive care plan) included the following interventions: "...Call light or personal items available and in easy reach or provide reacher. Footwear to provide slipping. Assist in ADL's [activities of daily living] and mobility as needed. Assure patient is monitored during mealtime if needed. Encourage choices with care. Feeds self after meal setup; monitor % [percentage] consumed; weight per protocol. Oral care assistance as needed...Continue to involve me in out of room activities like "people watching" in the small dayroom..."

Review of Resident #8's annual MDS dated 11/01/17 indicated this resident was non-ambulatory, with impairments in her ROM (range of motion) in all four extremities. Resident #8 was totally dependent for all her ADL's, including dressing, eating, hygiene, bathing and positioning. She was also totally incontinent of bowel and bladder.

Resident #8's CCP was never updated to include any of the deficits mentioned above. The ADON (assistant director of nursing) was interviewed on 02/01/18 at approximately 11:54 a.m. regarding

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who is responsible for updating the CCP. The ADON stated, "Mostly nursing, but all departments can update for themselves."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 02/01/18 at approximately 2:05 p.m. No further information was received by the survey team prior to the exit conference on 02/01/18.

5. Resident 51's care plan was not revised to include care and treatment for a new pressure sore.

Resident #51 was admitted to the facility on 3/9/17 with diagnoses that included schizoaffective disorder, panic disorder, anxiety, COPD (chronic obstructive pulmonary disease), tibia fracture and high blood pressure. The minimum data set (MDS) dated 12/20/17 assessed Resident #51 as cognitively intact.

Resident #51's clinical record documented a nursing note dated 1/28/18 stating the resident was assessed with a pressure ulcer on her right heel. The record documented a physician's order dated 1/28/18 for treatment to the resident's right heel ulcer each day with wound cleanser and a dry padded dressing.

On 1/31/18 at 1:30 p.m., the registered nurse (RN #4) responsible for wound care was observed performing a dressing change to a pressure ulcer on the resident's right heel according to the physician's order.

Resident #51's plan of care (print date 1/31/18)

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F 657	Continued From page 18 documented the resident was at risk of developing pressure ulcers due to decreased bed mobility and a history of skin tears and skin irritation. The resident's care plan was not revised to include any problems, goals and/or interventions regarding the newly developed pressure ulcer on the right heel. On 2/10/18 at 10:26 a.m., the licensed practical nurse (LPN #1) responsible for MDS and care plan development was interviewed about Resident #51's care plan. LPN #1 stated there was nothing on the care plan about the right heel ulcer. LPN #1 stated she routinely updated care plans during the quarterly review and the unit manager was responsible for revising care plans when any new problems and/or issues occurred. These findings were reviewed with the administrator and director of nursing during a meeting on 2/1/18 at 2:30 p.m.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, facility staff failed to document physician ordered fluid restrictions for	F 684	1. Resident #60 remains in the facility. Resident's order was updated to reflect resident's fluid restriction during survey. 2. Residents in the facility on fluid restriction have the potential to be effected by this deficient practice. An audit was completed on 2/01/2018 of residents with fluid restrictions to ensure orders were correct.	

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F 684	Continued From page 19 one of 22 residents in the survey sample, Resident #60. Facility staff failed to accurately document Resident #60's fluid intake in every 24 hour period as ordered by the physician. Findings included: Resident #60 was originally admitted to the facility on 04/19/16 and readmitted on 12/22/17 with diagnoses including, but not limited to: ESRD (end stage renal disease) requiring HD (hemodialysis), Respiratory Failure, Pleural Effusion, Pneumonia, Urinary Retention, Diabetes, Hypertension, Anxiety and Depression. The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 12/29/17. Resident #60 was assessed as cognitively intact with a total cognitive score of 13 out of 15. Resident #60's clinical record was reviewed on 01/30/18 at approximately 3:00 p.m. The current POS (physician order sheet) dated 02/01/18 included the following order: "...monitor pt. [patient] fluid intake, 50 oz. [ounces] q [every] 24 hours max [maximum] intake. every shift..." (sic) Subsequent review of the January 2018 MAR (medication administration sheet) included the 1500 cc (cubic centimeters) fluid restriction, but was noted by only a check in the box for each shift. No fluid intake amount was documented on the MAR per shift. The Task screen was also reviewed and again showed only checks in the boxes for fluid restrictions.	F 684	3. Licensed nursing staff will be re-educated on how to write orders for fluid restriction. Audits will be completed 5x per week x 3 months to ensure amount allocated has been given with appropriate documentation provided on MAR. 4. Results of audit will be taken to the monthly/ quarterly Quality Assurance Performance Improvement Committee for review. 5. Corrective action will be completed on March 1, 2018	

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F 684	Continued From page 20 On 02/01/18 at 11:50 a.m. the ADON (assistant director of nursing) was interviewed regarding documentation of fluid intake for residents on physician ordered fluid restrictions. The ADON stated, "We don't have a flowsheet. Dietary has limits per meals and nursing has limits. A physician order is usually written breaking down the limits per shift." The ADON stated at 1:35 p.m., We do not have a specific flowsheet to record fluid intake right now. I have written an order breaking down his fluid restrictions per shift." The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 02/01/18 at approximately 2:05 p.m. No further information was received by the survey team prior to the exit conference on 02/01/18.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 685	1. Resident #52 remains in facility. Facility contacted responsible party on 2/15/18 to obtain consent to send resident out of facility to audiologist for consult. Resident's family declined as resident has hearing aids at her home but in the past has refused to wear. Responsible party stated she will bring hearing aids into facility for facility to trial resident with them again.	

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F 685	Continued From page 21 interview and clinical record review, the facility staff failed ensure one of 22 residents in the survey sample received care and/or services for hearing loss for Resident # 52. The facility staff failed to ensure that Resident # 52 received a hearing evaluation and/or consult to address the resident's significant hearing loss. Findings include: Resident # 52 was admitted to the facility on 10/01/14 with diagnoses including, but not limited to: major depressive disorder, anxiety disorder, high blood pressure, hypothyroidism, and urinary retention. The resident did not have an actual diagnoses of hearing loss listed on the resident's CCP or on the POS (physician's order set). The most current MDS (minimum data set) was a quarterly assessment dated 12/20/17. This MDS assessed the resident as having a cognitive score of "3", indicating the resident was severely impaired in daily decision making skills. The resident was also assessed on this MDS, as having moderate difficulty hearing and not having/using a hearing aid or device. On 01/30/18 at 10:45 a.m. during the initial tour of the facility, Resident # 52 was observed in her room laying in bed. This surveyor knocked on the door and requested to come in. The resident did not respond. The same was done, with a louder knock and tone of voice and the resident did not respond. The resident was looking at the door area, but did not respond. The surveyor moved closer and spoke in a very loud tone and the resident said, "What" and then attempted to sit up on the side of the bed. The surveyor made	F 685	2. Residents in the facility identified with hearing loss have the potential to be affected by this deficient practice. 3. An audit will be conducted to identify residents with hearing impairment. Residents identified will have consents obtained and if applicable, audiology consults will be scheduled. Nursing staff were educated on 2/21/2018 to notify social services of any resident with suspected hearing loss. Social services will then contact responsible party to address hearing loss and schedule appointments if desired. 4. Results of audits will be taken to the monthly/ quarterly Quality Assurance Performance Improvement for review. 5. Corrective action will be completed on March 1, 2018.	

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introductions in a very loud tone, but the resident could not hear what was being said.

02/01/18 08:04 AM the resident was observed in the day room area close to the nursing station and near the resident's room. The resident is in a w/c, the resident was spoken to again, but the resident is is very HOH (hard of hearing).

The resident's clinical record was reviewed and no evidence was found that the resident had any type of hearing aids or devices. No evidence could be found that the resident had seen an audiologist or had any type of consult for the hearing loss. No information was found in the resident's clinical record to indicate what caused the hearing loss or how long the resident had the hearing loss.

The resident's CCP documented, "...at risk for falls...cognition impairment, blind in L (left) eye, hearing impairment....impaired neurological status...HOH [hard of hearing]...Hearing and/or vision consultation as needed..." This CCP was initiated on 10/01/14, the resident's original admission and has a revision date of 01/16/17, but no actual revision was seen-only a revision date.

On 02/01/18 at 10:55 AM The ADON was interviewed regarding Resident # 52's hearing loss and difficulty communicating due to the hearing loss. The ADON stated that the resident did not have a hearing aid and could not remember the resident having one in the past, but did think that the resident had been tried on an amplifier at one point, but could not remember and would have to look that up. The ADON was

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F 685	Continued From page 23 informed of the resident's CCP (comprehensive care plan) having minimal information and interventions regarding the resident's extensive hearing loss and no information regarding any type of assistive hearing devices. The ADON was asked if the resident had any type of consultation for hearing, as referenced in the resident's CCP. The ADON stated that she would look for that information. On 02/01/18 at 11:50 AM, the ADON stated that there was no hearing consultation of any kind found for Resident # 52 and further stated that medical records is looking. The administrator and DON (director of nursing) were informed on 02/10/18 at approximately 2:30 p.m., in a meeting with the survey team of concerns with the degree of Resident # 52's hearing loss and that no information and/or documentation could be located in the resident's clinical records to indicate that the resident's hearing loss had been addressed. No further information and/or documentation was presented prior to the exit conference on 02/01/18 at 4:00 p.m.	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure a safe room environment for three of 22 residents in the survey sample. Resident #51 had a loose bed rail and the bed control remote cable was in disrepair with exposed wiring. The right brake had an exposed, rough tip on Resident #58's wheelchair due to a missing handle and her bed control remote cable had exposed wiring. The bed remote cable for Resident #83 was in disrepair with wiring exposed. The findings include: 1. Resident #51 was using a loose bed rail and the cable to the bed remote was in disrepair with exposed wiring. Resident #51 was admitted to the facility on 3/9/17 with diagnoses that included schizoaffective disorder, panic disorder, anxiety, COPD (chronic obstructive pulmonary disease), tibia fracture and high blood pressure. The minimum data set (MDS) dated 12/20/17 assessed Resident #51 as cognitively intact. On 1/30/18 at 11:17 a.m., Resident #51 was observed in bed. Resident #51 grabbed the left quarter length rail on her bed to adjust her positioning. The left bed rail was loose, moving back and forth as the resident pressed and pulled on the rail. In addition, the cable to the bed control remote was in disrepair with multi-colored wiring visible through broken, missing sections of the cable covering. Resident #51 was interviewed at this time about the loose rail and	F 689	1. Residents #51, #58, and #83 remain in the facility. The loose bedrail for resident #51 was repaired during survey. The wheelchair brake for resident #58 has been repaired. Bed controls for Residents #51, #58, and #83 with cracked, protective outer coating were repaired during survey. Audits were completed of bed controls and repaired by using electrical tape to cover. Beds identified with controls having cracked, protective outer coating were repaired and an order was placed for new controls. Replacement controls have been received in facility and maintenance currently replacing controls. 2. Bedrails, bed controls, and wheelchairs in the facility have the potential to be affected by this deficient practice. Bedrails, bed controls, and wheelchairs in the in facility will be assessed by Maintenance to identify any repairs or adjustments.	

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the exposed wiring. Resident #51 stated she used the rails to reposition in bed and she was not aware of the wiring exposed on the bed control cable.

On 1/30/18 at 11:27 a.m., the licensed practical nurse (LPN # #3) caring for Resident #51 was shown the loose rail, and exposed wires. LPN #3 was interviewed about the items in disrepair. LPN #3 stated maintenance used to go through rooms and make a list if needed repairs. LPN #3 stated work orders were supposed to be written for items needing repair. LPN #3 stated she would report the loose rail and exposed wiring to the maintenance director.

On 1/31/18 at 2:30 p.m., the maintenance director was interviewed about Resident #51's loose bed rail and exposed wiring on the bed remote. The maintenance director stated Resident #51's bed rail was loose from use and needed to be tightened. The maintenance director stated residents tended to wrap the bed remote cables around the bed rails resulting in cracks to the cable covering. The maintenance director stated exposed wires underneath the covering were insulated and the remotes were still working. The maintenance director stated the broken cable covers presented little risk to the resident because the cable/remote was "low voltage." The maintenance director stated he repaired the bed cables when reported but did not perform routine maintenance on the bed remotes.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/1/18 at 10:30 a.m.

3. Education will be provided by DNS/designee to report loose bedrails/damaged bed controls and missing/damaged wheelchair brake handles and rods to Maintenance for repair and adjustments. Audits will be done 5x weekly during Care Keeper Rounds to ensure bedrails are not loose and bed controls are without cracked, protective outer coating. Audits will be conducted by the shower team weekly to ensure brake handles and rods are in place.

Maintenance will complete monthly audits on beds to identify controls with cracked protective outer coating, loose side rails needing repair and damaged wheelchair brake handles and rods.

4. Results of these audits will be taken to Quality Assurance for review and with appropriate recommendations made. These audits will be ongoing and the QAPI committee responsible for ongoing compliance.

5. Date of completion March 1, 2018.

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2. The right brake rod had an exposed, rough tip on Resident #58's wheelchair due to a missing handle. Resident #58's bed control remote cable had exposed wiring.

Resident #58 was admitted to the facility on 6/2/17 with a re-admission on 9/21/17. Diagnoses for Resident #58 included high blood pressure, diabetes, heart disease, depression, anxiety, history of breast cancer, lymphedema and chronic kidney disease. The minimum data set (MDS) dated 12/27/17 assessed Resident #53 with moderately impaired cognitive skills.

On 1/30/18 at 11:30 a.m., Resident #58 was observed in her wheelchair self-propelling in her room. The right brake on the resident's wheelchair had an exposed, rough tip due to a missing handle cover. The brake rod had two pieces of pink foam taped to the middle section of the rod. Resident #58 was interviewed at this time about the missing brake handle. The resident stated the handle grip broke and someone taped the foam pieces over the rod for her to use as a handle. The resident stated the foam pieces were loose and did not cover the tip of the brake rod.

On 1/31/18 at 8:47 a.m., Resident #58's bed remote cable was observed with a cracked covering and exposed wiring. The maintenance director came in the room at the time of this observation and covered the broken cable with tape. The maintenance director was interviewed at this time about the broken cable and exposed wires. The maintenance director stated some of the bed remote cables were cracked/broken with wires exposed and he was covering them temporarily with tape.

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On 1/31/18 at 8:52 a.m., accompanied by the registered nurse (RN #3) caring for Resident #58, the missing brake handle cover was observed. RN #3 was interviewed at this time about the rough brake rod and missing handle. RN #3 stated, "Looks like someone just put a temporary fix on it [handle]." RN #3 stated she thought therapy was responsible for replacing the missing handle on the brake rod and stated the brake handle needed a "permanent fix."

This finding was reviewed with the administrator and director of nursing during a meeting on 2/1/18 at 10:30 a.m.

3. The bed control cable for Resident #83 was in disrepair with wiring exposed.

Resident #83 was admitted to the facility on 12/26/17 with diagnoses that included sacral pressure ulcer, high blood pressure, anemia and osteomyelitis. The minimum data set (MDS) dated 1/9/18 assessed Resident #83 as cognitively intact.

On 1/31/18 at 9:02 a.m., Resident #83 was observed in bed. A section of cable to the resident's bed remote was covered with repair tape. Resident #83 was interviewed at this time about the bed remote cable. Resident #83 stated the bed control remote cable covering was broken in places with the multi-color wires exposed. Resident #83 stated the remote was still working but "You could see the wires." Resident #83 stated someone from the shop had just been in the room and covered the cable with tape.

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F 689	Continued From page 28 On 1/31/18 at 2:30 p.m., the maintenance director was interviewed about the exposed wiring on the bed remotes. The maintenance director stated residents tended to wrap the bed remote cables around the bed rails resulting in cracks to the cable covering. The maintenance director stated exposed wires underneath the covering were insulated and the remotes were still working. The maintenance director stated the broken cable covers presented little risk to the resident because the cable/remote was "low voltage." The maintenance director stated he repaired the bed cables when reported but did not perform routine maintenance on the bed remotes. These findings were reviewed with the administrator and director of nursing during a meeting on 2/1/18 at 10:30 a.m.	F 689		
F 700 SS=F	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700	1. Resident #51 remains in the facility. Bedrails for resident #51 was repaired during survey. Residents #5, #6, #8, #25, #36, #51, #52, #56, #58, #59, #60, #63, #83, and #287 remain in the facility. These beds identified at risk of entrapment will be assessed for replacement and/or repaired. Extenders or proper devices to correct identified space have been ordered to resolve identified safety issues.	

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§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess and/or implement interventions to ensure safe bed rail use throughout the facility for 18 of 18 current residents in the survey sample (Residents #5, #6, #7, #8, #25, #35, #36, #42, #51, #52, #56, #58, #59, #60, #61, #63, #83 and #287.) This resulted in the identification of substandard quality of care.

Overall, bed rail assessments of thirty-six (36) resident beds indicated risks of entrapment due to gap measurements beyond those recommended by the Food and Drug Administration (FDA). There were no interventions implemented in response to the assessments to minimize and/or eliminate entrapment risks from the bed rails. This included the beds for Residents #6, #7, #52, #56, #59, #60, #61, #63, and #287.

The remaining fifty-one (51) beds in the facility were not assessed for entrapment risks. This included the beds for Residents #5, #8, #25, #35, #36, #42, #51, #58, and #83

The findings include:

On 1/30/18 at 11:17 a.m., Resident #51 was observed in bed. Resident #51 grabbed the left

2. Beds with rails in the facility have the potential to be affected by this deficient practice. Beds with rails in this facility will be assessed by Maintenance to identify entrapment potential.
3. Residents' beds will be inspected for safe operation, risk of entrapment, for comfort and potential for other adverse events. Maintenance will conduct a monthly inspection of bedrails in use to ensure bed rails are securely attached to bed frame along with the inspection of electronic bed controls. Bed tracking will be completed in TELS (electronic maintenance logs). Staff will be educated on immediate reporting of any identified loose bed rails.
4. Results of audits will be taken to the monthly/quarterly Quality committee responsible for ongoing compliance.
5. Corrective action will be completed on March 1, 2018.

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quarter length rail on her bed to adjust her positioning. The left bed rail was loose, moving back and forth as the resident pressed and pulled on the rail.

On 1/30/18 at 11:27 a.m., the licensed practical nurse (LPN # #3) caring for Resident #51 was interviewed about the loose bed rail. LPN #3 stated she would report the loose rail to the maintenance director.

On 2/1/18 at 8:00 a.m., the maintenance director was interviewed about Resident #51's loose bed rail. The maintenance director stated the rail was loose due to resident use and was tightened. The maintenance director was interviewed at this time about routine maintenance and safety checks for bed rails in the facility. The maintenance director stated he fixed loose bed rails when there was a reported problem.

When asked if any routine safety checks or inspections were performed on bed rails to minimize entrapment risks, the maintenance director stated he started assessing bed rails for entrapment risks in November 2017 in response to the new regulations.

The maintenance director stated all beds in the facility had quarter length bed rails mounted near the head of the beds. The maintenance director stated older beds already had side rails in place and side rails were installed for any new beds purchased.

The maintenance director presented a book of check sheets titled Bed System Measurement Device Test Results Worksheet. These sheets had a bed diagram showing potential entrapment

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zones (1 through 4) with spaces to indicate if the zone measurements met the recommended FDA gap measurements for safety or failed, indicating a potential entrapment risk.

There were thirty-six bed rail safety assessments dated from 11/17/17 through 11/30/17. All thirty-six assessments presented by the maintenance director documented potential entrapment risks in one or more measured areas (zones 1 through 4). This included the beds of Residents #6, #7, #52, #56, #59, #60, #61, #63, #287.

The maintenance director stated the facility borrowed a device for measuring the bed rail gaps and the measurements indicated failures on all the beds he checked. .

When asked what actions were taken in response to the failed tests, the maintenance director stated he was told near the end of November (2017) all the bed rails were to be removed. The maintenance director stated he then got word from nursing that the rails were not to be removed. The maintenance director stated the facility was "going back and forth" about using the bed rails. The maintenance director stated the bed rails were currently still in place on resident beds.

On 2/1/18 at 8:05 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed about bed rails and the maintenance assessments indicating entrapment risks due to gap measurements beyond the FDA recommended guidelines. The DON stated the facility borrowed a "tool" from another facility so the maintenance director could check the bed rail

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gaps in response to the new regulations. The DON stated bed rails were not eliminated and rails were currently in place on all the facility beds. The DON stated residents had a quarterly nursing assessment that included a section on side rail use. The ADON stated the side rail assessment on the nursing assessment was "vague" and did not include specific assessments regarding entrapment risks. When asked what interventions had been taken in response to the failed gap measurement checks, the DON stated, "Nothing at this point."

On 2/1/18 at 8:40 a.m., the administrator, DON and maintenance director were interviewed by the survey team concerning the bed rail assessments indicating entrapment risks. The maintenance director stated they borrowed a "tool" from another facility to assess if the bed rail gap measurements met the FDA requirements in zones 1 through 4.

When asked if all the beds in the facility had been assessed, the maintenance director stated, "No." The maintenance director stated when he got word that the rails were going to be removed, he stopped performing the gap measurements because he saw no need to continue measuring if the rails were going to be removed. This means that Residents #5, #8, #25, #35, #36, #42, #51, #58, and #83 beds were not evaluated for risk of entrapment.

The maintenance director stated he stopped the bed rail assessments "at the end of November [2017]."

The DON stated the rails were left on the beds and nursing was supposed to evaluate each

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resident for safe bed rail use. The DON stated until the residents were individually assessed, she understood the rails were considered a restraint. The DON stated the quarterly nursing side rail assessments did not incorporate anything about the bed rail gap measurements performed by maintenance.

The maintenance director stated the plan in November 2017 to remove all the bed rails was related to the new regulations about bed rail safety and was not in response to the failed bed assessments conducted in the facility. When asked if he informed his administrator or corporate about the failed gap measurements for the 36 bed assessments done, the maintenance director stated, "No. I don't think so." When asked again if anyone in administration knew about the failed bed rail assessments indicating entrapment risks, the maintenance director stated, "No."

The administrator stated the facility had a total of 87 beds. The administrator stated the facility was "moving toward" getting rid of bed rails but had not made a decision to eliminate rails. The administrator stated she had not seen the bed rail assessment sheets conducted in November 2017 indicating entrapment risks.

After consulting with the state agency supervisors, the facility was advised on 2/1/18 at 10:10 a.m. that substandard quality of care was identified related to the facility's failure to assess and implement interventions to ensure safe bed rail use throughout the facility. The thirty-six bed rail assessments performed in November 2017 indicated entrapment risks due to gap measurements greater than FDA guidelines for

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safe rail use and the remaining resident beds in the facility had not been assessed. There were no interventions implemented in response to the assessed entrapment risks. Residents in the facility including the eighteen residents in the survey sample did not have individualized bed rail assessments related specifically to entrapment risks and there were no documented attempted alternatives to bed rail use.

On 2/1/18 at 11:00 a.m., the maintenance director was interviewed about any facility policy or guidelines regarding bed rail audits or assessments for safety including entrapment risks. The maintenance director stated they did not have a facility policy but went by the FDA dimension guidelines for bed rail safety.

These findings were reviewed with the administrator and director of nursing on 2/1/18 at 10:10 a.m. and during a meeting on 2/1/18 at 2:30 p.m.

The Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment on pages 2 and 3 defines entrapment as, "...an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries...These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body

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movement...Long-term care facilities reported the majority of the entrapments..." This reference on pages 15 through 18 documents the following dimensional recommendations by identified entrapment zones:

Zone 1 - Within the rail - "...any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering... A loosened bar or rail can change the size of this space... recommend this space to be less than 120 mm [millimeters] (4 3/4 inches)..."

Zone 2 - Under the rail between the rail supports or next to a single rail - "This space is the gap under the rail between mattress compressed by the weight of a patient's head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support... FDA recommends that this space be small enough to prevent head entrapment, less than 120 mm (4 3/4 inches)..."

Zone 3 - Between the rail and the mattress - "This area is the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. This space should be small enough to prevent head entrapment when taking into account the mattress compressibility, any lateral shift of the mattress or rail, and degree of play from loosened rails...recommend a dimension of less than 120 mm (4 3/4 inches) because the head is presumed to enter the space before the neck..."

Zone 4 - Under the rail at the ends of the rail - "This space is the gap that forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail.

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F 700	Continued From page 36 Factors that may increase the gap size are: mattress compressibility, lateral shift of the mattress or rail, and degree of play from loosened rails. The space poses a risk for entrapment of a patient's neck...FDA recommends that the dimensional limit for this space also be less than 60 mm (2 3/8 inches)..." (1) (1) Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. March 10, 2006. U.S. Department of Health and Human Services Food and Drug Administration. 2/2/18 www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm072729.pdf	F 700		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, and clinical record review the facility failed to ensure a medication error rate less than 5 percent. There were two errors out of 33 opportunities resulting in a medication error rate of 6.06 percent. Resident #56 had a physician order for SSI (sliding scale insulin) to be administered before meals. Resident #56 had eaten breakfast before	F 759	1. Resident #56 remains in the facility. Physician was notified of medication error. Resident without adverse outcome. Identified nurse and education on medication administration guidelines was completed. 2. Residents receiving insulin could have the potential of being affected by this deficient practice	

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F 759	Continued From page 37 his blood sugar was obtained and before his insulin was given.. Findings were: A medication pass and pour observation was conducted on 01/31/2018 with LPN (license practical nurse) #2, beginning at 8:10 a.m. At 8:31 a.m., LPN # 2 began preparing medications for Resident #56. She entered Resident #56's room and did a fingerstick blood sugar. The reading was 335. LPN #2 returned to the medication cart, referred to the order and prepared 12 units of Humalog insulin for administration. She returned to Resident #56's room and administered the insulin. An empty food tray was observed next to Resident #56's bed. He was asked if he had eaten breakfast. He stated, "Yes, eggs, cheerios, and apple juice." LPN #2 returned to the medication cart. This surveyor asked if the SSI was ordered to be administered before or after meals. She stated, "It's ordered for 8:00 a.m. She then reviewed the order and stated, "It is suppose to be given before meals...I need to get the time changed on that." The clinical record was reviewed. The following order was observed: "Humalog Solution 100 unit/ml...Inject as per sliding scale...subcutaneously before meals related to Type 2 diabetes mellitus..." The above information was discussed during a meeting with the administrator and the DON (director of nursing) on 01/31/2018. No further information was obtained prior to the exit conference on 02/01/2018.	F 759	3. Licensed nurses will be educated on the five rights of administration DNS/designee will conduct medication pass observation weekly to assure medications are being administered per physician order over the next three months. 4. Results of audits will be taken to Quality Assurance Performance Improvement for review and recommendations for three months with Quality Assurance Performance Improvement committee responsible for ongoing compliance. 5. Corrective action will be completed by March 1, 2018.	

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F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide menus of choice for one of 22 residents in the survey sample, Resident #59. Resident #59 was not provided with menu choices based on her preference of being a vegetarian.	F 803	1. Resident #59 remains in the facility. Resident was provided a vegetarian menu and education regarding proper protein consumption by the Dietician during survey. 2. Residents with vegetarian preferences can be affected by this deficient practice. 3. Upon admission or change of dietary preference during facility stay, will be provided with a vegetarian menu and provided education on proper protein consumption. An audit of residents' diets will be conducted on current residents. Random weekly audits of residents' diets will also be conducted for the next 3 months.	

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F 803	Continued From page 39 Findings were: Resident #59 was admitted to the facility on 12/15/2017 with the following diagnoses, but not limited to: Major depressive disorder, urinary tract infection, degenerative disease of the nervous system,and hypothyroidism. The admission MDS (minimum data set) assessed Resident #59 as having a cognitive summary score of "15", indicating she was cognitively intact. Resident #59 was interviewed on 01/30/2018 at 1:25 p.m. regarding her life at the facility. During the interview, Resident #59 stated that she was a vegetarian by choice. Resident #59 was asked what the facility was providing her nutritionally to meet her protein needs. She stated, "Someone came in and talked to me about what I like... I circled several things on the menu... They told me my mom could bring things I want like veggie burgers and they would serve them but she hasn't done that yet Resident #59 was observed eating lunch on 01/30/2018. Her tray consisted of mashed potatoes, green beans and jello. Resident #59 was asked what protein she had been served for lunch. She stated, "I guess the mashed potatoes are my protein." Resident #59 was asked if she ate eggs or other dairy products. She stated, "I eat cheese, no eggs, I just don't like them, but I will eat them if they are cooked in something." The clinical record was reviewed on 01/30/2018 at approximately 3:00 p.m. The diet order on her physician order sheet was, "Regular". The care plan was reviewed. There were no interventions	F 803	4. Results of audits will be taken to Quality Assurance Performance Improvement for review and recommendations for three months with Quality Assurance Performance Improvement committee responsible for ongoing compliance. 5. Corrective action will be completed on March 1, 2018.	

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F 803	Continued From page 40	F 803		

for Resident #59's vegetarian status. Observed in the clinical record was a "Diet Requisition Form" dated 12/19/2017 and signed by the unit manager. Comments on the bottom of the sheet were: "Please do not send meat. Resident is a vegetarian, per resident request."

On 01/31/2018 this surveyor asked to speak with the dietary manager. The dietary manager stated that she had only been a the facility for three days. The regional dietary manager stated that he was not familiar with the resident, however, the RD (regional dietician) was in the building. The RD was interviewed on 01/31/2018 at 10:15 a.m. The RD stated that when she first met with Resident #59 she did not mention that she was a vegetarian. The RD was asked about the dietary requisition form that was sent to the kitchen on 12/19/2017. The RD stated that the requisition form should have prompted a visit by the DM to get the resident's choices. She stated that she could not find any documentation that the visit had occurred. The RD continued that Resident #59 was on a "Choice menu", meaning she picked what she wanted to eat by circling it on the menu. The RD was asked how the facility ensured that Resident #59 was meeting her protein needs, since Resident #59 had identified mashed potatoes as a protein source. The RD stated, "She makes her own choices, it isn't up to me to make sure she is making good choices." The RD was asked to show this surveyor an example of the menu given to Resident #59 to make her meal choices. The RD left the room and returned with a menu. Each meal listed contained a meat choices. Listed for Wednesday was: "WEDNESDAY DINNER: Chicken chili, vegetable blend, corn bread, and mandarin oranges. ALWAYS AVAILABLE: SOUP: Chicken

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F 803	Continued From page 41 noodle or tomato, HOT SANDWICH SELECTION: Hot Dog, Hamburger/Cheeseburger, Grilled Cheese, Chicken salad ALWAYS AVAILABLE SALAD Tossed salad with ranch, french or Italian dressing, SIDE DISH Cottage Cheese, green beans, mashed potato..." The RD was asked what the protein choice listed on the menu would be for Resident #59. She stated, "We always offer cottage cheese". The RD was asked if the menu she presented was geared towards vegetarians since the only item listed for them for protein was cottage cheese. The RD stated that she would go and speak with Resident #59 about her diet and her choices. The RD returned to the conference room at approximately 2:00 p.m. She presented a different menu for "Lacto-Ovo Vegetarian" choices. She stated, "I met with [name of Resident 59] and we went over this menu...she got this one last week to choose from...she circled what she wants. I also educated her on good protein choices." The above information was discussed during a meeting on 01/31/2018. No further information was obtained prior to the exit conference on 02/01/2018.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812	1. Muffin pans and trays were removed from shelf, re-sanitized and air dried per policy during survey.	

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F 812	Continued From page 42 state or local authorities. (I) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (II) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility failed to ensure pans identified as cleaned and dried were not nested wet. Findings include: The kitchen was inspected 1/30/18 beginning at 10:35 a.m. with the Dietary Manager (DM) and regional dietary manager. During the inspection, the regional dietary manager was asked to randomly lift a stack of sheet pans, identified as clean and dry and ready for use. The regional dietary manager lifted the top three of 10 sheet pans, and one was nested wet. This surveyor then asked the remaining pans be lifted, and two more pans were nested wet. The DM removed the wet pans and put them to be washed. The regional dietary manager was then asked to lift a stack of muffin pans, also identified as clean, dry, and ready for use. Two of the seven muffin pans were nested wet. The DM also removed those pans to be washed.	F 812	2. Sanitized trays and muffin pans have the potential of being affected by this deficient practice. 3. Education to dining staff on proper air drying of trays and muffin pans will be provided by the Dining Manager. An audit will be conducted weekly to monitor proper storage of sanitized dishes over the next 3 months. 4. Results of audits will be taken to Quality Assurance Performance Improvement for review and recommendations for three months with Quality Assurance Performance Improvement committee responsible for ongoing compliance. 5. Corrective action will be completed on March 1, 2018.	

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F 812	Continued From page 43 On 1/31/18 during a meeting with facility staff beginning at 3:45 p.m. the administrator was asked if there was a policy on drying pans in the kitchen; she stated she would find out. On 1/31/18 a policy "Manual Ware Washing" was presented to this surveyor. The "Policy Statement" of the policy stated "It is the center policy to insure (sic) all service ware and cook ware that is not processed through the dish machine will be washed and sanitized." Under "Action Steps" was documented "3. The Food Services Director insures (sic) that all service ware and cookware are air dried to storage." No further information was provided prior to the exit conference.	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on survey findings and staff interviews, the facility administrator failed to provide effective administration to prevent substandard quality of care in the area of Quality of Care. Findings were: An onsite survey was conducted from 01/30/2018 through 02/1/2018. During the survey deficient	F 835	1. Physicians for Residents #5, #6, #7, #8, #25, #35, #36, #42, #51, #52, #56, #58, #59, #60, #61, #63, #83, and #287 will be notified of each resident who was found to have received substandard quality of care during survey. A certified letter to the State Board of Licensure will be sent by the Administrator to notify of substandard quality of care during survey. 2. Residents residing in the facility have the potential to be affected by this deficient practice.	

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F 835	Continued From page 44 practice was identified in the area of quality of care, at F700 with a scope and severity level of 2, wide spread regarding the facility's failure to ensure all beds in the facility were in compliance with risk areas of bed entrapment. Substandard quality of care was initiated on 2/1/18. During the process, interviews took place with the administrator, regional clinical director and the director of nursing. The regional director verbalized that maintenance did not inform the administrator or clinical director of the beds not being in compliance (the administrator agreed). DON verbalized that she was informed of the concern with the bed rails but related the concern with the bed rails being a problem in terms of restraints, not in terms of the bed rails were out of compliance for entrapment. The administrator verbalized that she should have been made aware of the concern so that she could have complied with the regulation. No further information was provided prior to the exit conference on 2/1/18.	F 835	3. Education will be provided to administrative team regarding appropriate reporting to the Administrator. New company/CMS policies will be reviewed and implemented as they are disseminated with any action items and follow-up identified. 4. Administrator will review TELS (electronic maintenance logs) on a monthly basis with results reported on a monthly basis during Quality Assurance meeting/ QAPI and any immediate action items will be followed up on during daily stand down meetings. 5. Corrective action will be completed on March 1, 2018.	
F 909 SS=F	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by:	F 909		

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F 909	Continued From page 45 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to conduct routine inspections of beds and/or bed rails throughout the facility to identify areas of possible entrapment. Bed rail assessments of thirty-six (36) resident beds indicated risks of entrapment due to gap measurements beyond those recommended by the Food and Drug Administration (FDA). There were no interventions implemented in response to the assessments to minimize and/or eliminate entrapment risks from the bed rails. The remaining fifty-one (51) beds in the facility were not assessed for entrapment risks. There was no facility policy or program established for regular maintenance or bed audits to identify potential areas of entrapment. The findings include: On 1/30/18 at 11:17 a.m., Resident #51 was observed in bed. Resident #51 grabbed the left quarter length rail on her bed to adjust her positioning. The left bed rail was loose, moving back and forth as the resident pressed and pulled on the rail. On 1/30/18 at 11:27 a.m., the licensed practical nurse (LPN # #3) caring for Resident #51 was interviewed about the loose bed rail. LPN #3 stated she would report the loose rail to the maintenance director. On 2/1/18 at 8:00 a.m., the maintenance director was interviewed about Resident #51's loose bed rail. The maintenance director stated the rail was loose due to resident use and was tightened. The maintenance director was interviewed at this time about routine maintenance and safety	F 909	1. Resident #51 remains in the facility. The loose bedrail for resident #51 was repaired during survey. The 36 beds identified at risk of entrapment will be assessed for replacement and/or repaired. The remaining 51 beds in the facility will be assessed for risk of entrapment potential with appropriate repairs or replacements as needed. 2. Beds in the facility have the potential to be affected by this deficient practice. 3. Education will be provided by DNS/designee to report loose bedrails to Maintenance for repairs and adjustments. Audits will be done 5x weekly during Care Keeper Rounds to ensure bedrails are not loose. Maintenance will complete monthly audits on beds to identify loose side rails needing repair. 4. Results of these audits will be taken to Quality Assurance for review and recommendation for three months with the QAPI committee responsible for ongoing compliance. 5. Date of completion March 1, 2018.	

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checks for bed rails in the facility. The maintenance director stated he fixed loose bed rails when there was a reported problem. When asked if any routine safety checks or inspections were performed on bed rails to minimize entrapment risks, the maintenance director stated he started assessing bed rails for entrapment risks in November 2017 in response to the new regulations. The maintenance director stated all beds in the facility had quarter length bed rails mounted near the head of the beds. The maintenance director stated older beds already had side rails in place and side rails were installed for any new beds purchased. The maintenance director presented a book of check sheets titled Bed System Measurement Device Test Results Worksheet. These sheets had a bed diagram showing potential entrapment zones (1 through 4) with spaces to indicate if the zone measurements met the recommended FDA gap measurements for safety or failed, indicating a potential entrapment risk. There were 36 bed rail safety assessments dated from 11/17/17 through 11/30/17. All thirty-six assessments presented by the maintenance director documented potential entrapment risks in one or more measured areas (zones 1 through 4). The maintenance director stated the facility borrowed a device for measuring the bed rail gaps and the measurements indicated failures on all the beds he checked. When asked what actions were taken in response to the failed tests, the maintenance director stated he was told near the end of November (2017) all the bed rails were to be removed. The maintenance director stated he then got word from nursing that the rails were not to be removed. The maintenance director stated the facility was "going back and forth" about using the bed rails. The maintenance director stated

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F 909	Continued From page 47 the bed rails were currently still in place on resident beds. On 2/1/18 at 8:05 a.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed about bed rails and the maintenance assessments indicating entrapment risks due to gap measurements beyond the FDA recommended guidelines. The DON stated the facility borrowed a "tool" from another facility so the maintenance director could check the bed rail gaps in response to the new regulations. The DON stated bed rails were not eliminated and rails were currently in place on all the facility beds. The DON stated residents had a quarterly nursing assessment that included a section on side rail use. The ADON stated the side rail assessment on the nursing assessment was "vague" and did not include specific assessments regarding entrapment risks. When asked what interventions had been taken in response to the failed gap measurement checks, the DON stated, "Nothing at this point." On 2/1/18 at 8:40 a.m., the administrator, DON and maintenance director were interviewed by the survey team concerning the bed rail assessments indicating entrapment risks. The maintenance director stated they borrowed a "tool" from another facility to assess if gap measurements with bed rails met the FDA requirements in zones 1 through 4. When asked if all the beds in the facility had been assessed, the maintenance director stated, "No." The maintenance director stated when he got word that the rails were going to be removed, he stopped performing the gap measurements because he saw no need to continue measuring if the rails were going to be removed. The maintenance director stated he	F 909		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 48	F 909		

stopped the bed rail assessment "at the end of November [2017]." The DON stated the rails were left on the beds and nursing was supposed to evaluate each resident for safe bed rail use. The DON stated until the residents were individually assessed, she understood the rails were considered a restraint. The DON stated the quarterly nursing side rail assessments did not incorporate anything about the bed rail gap measurements performed by maintenance. The maintenance director stated the plan in November 2017 to remove all the bed rails was related to the new regulations about bed rail safety and was not in response to the failed bed assessments conducted in the facility. When asked if he informed his administrator or corporate about the failed gap measurements for the 36 bed assessments done, the maintenance director stated, "No. I don't think so." When asked again if anyone in administration knew about the failed bed rail assessments indicating entrapment risks, the maintenance director stated, "No." The administrator stated the facility had a total of 87 beds. The administrator stated the facility was "moving toward" getting rid of bed rails but had not made a decision to eliminate rails. The administrator stated she had not seen the bed rail assessment sheets conducted in November 2017 indicating entrapment risks.

On 2/1/18 at 11:00 a.m., the maintenance director was interviewed about any facility policy or guidelines regarding bed rail audits or assessments for safety including entrapment risks. The maintenance director stated they did not have a facility policy but went by the FDA dimension guidelines for bed rail safety.

These findings were reviewed with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 02/01/2018

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F 909	Continued From page 49 administrator and director of nursing on 2/1/18 at 10:10 a.m. and during a meeting on 2/1/18 at 2:30 p.m. The Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment on pages 2 and 3 defines entrapment as, "...an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries...These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement...Long-term care facilities reported the majority of the entrapments..." This reference on pages 15 through 18 documents the following dimensional recommendations by identified entrapment zones: Zone 1 - Within the rail - "...any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering... A loosened bar or rail can change the size of this space... recommend this space to be less than 120 mm [millimeters] (4 3/4 inches)..." Zone 2 - Under the rail between the rail supports or next to a single rail - "This space is the gap under the rail between mattress compressed by the weight of a patient's head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support... FDA	F 909		

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recommends that this space be small enough to prevent head entrapment, less than 120 mm (4 3/4 inches)..."

Zone 3 - Between the rail and the mattress - "This area is the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. This space should be small enough to prevent head entrapment when taking into account the mattress compressibility, any lateral shift of the mattress or rail, and degree of play from loosened rails...recommend a dimension of less than 120 mm (4 3/4 inches) because the head is presumed to enter the space before the neck..."

Zone 4 - Under the rail at the ends of the rail - "This space is the gap that forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. Factors that may increase the gap size are: mattress compressibility, lateral shift of the mattress or rail, and degree of play from loosened rails. The space poses a risk for entrapment of a patient's neck...FDA recommends that the dimensional limit for this space also be less than 60 mm (2 3/8 inches)..." (1)

(1) Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. March 10, 2006. U.S. Department of Health and Human Services Food and Drug Administration. 2/2/18 www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm072729.pdf